OPHTHALMOLOGY.

42. *Eradication of Inverted Eyelashes.*—In cases where the eyelashes are inverted, causing irritation to the ball, but in which the edges of the lids *retain their natural direction*, Dr. James Hunter applies an irritant to the hair bulbs, to destroy their reproductive function, and for this purpose he has found the tartar emetic to answer best. This method of proceeding is as follows:—

1. *To ascertain the presence and position of the inverted eyelashes.* When they are white coloured, and of extreme delicacy, not exceeding $\frac{1}{800}$ of an inch in diameter, as is often the case, it is very difficult to distinguish them; the edge of the lid should be brought in contact with the cornea, so that the pupil or iris may form a good contrasting background, and though they may not be visible at once, the surgeon should look from a variety of positions, and alter the direction of the light till he sees them. A convex lens of two inches focus, and not less than an inch in diameter, should be held by an assistant so as to condense the light on the parts, which is a much better plan than using it as a magnifier. If, in order to make the puncture, the edge of the lid is to be removed from the cornea, it is well first of all to blacken the pale and delicate eyelashes with any dark extract, such as belladonna, to render them visible, when contrasted with the white sclerotic coat. 2. *The puncturing of the bulbs.*—This should be done with a lancet, or iris knife, entered close to the base of the inverted hairs, *in the direction of their growth*, to the depth of an eighth of an inch, and moved about a little, so as to widen the bottom of the wound, and cut the bulbs. In doing this, it is sometimes advantageous to stretch the part either with a small hook, or over a convex black horn spatula, such as is usually attached to the German wire speculum. 3. *The inoculation.*—This must be deferred till the bleeding has wholly ceased, when the lid being wiped very dry, the drilled end of a darning-needle slightly damped, and dipped in powdered tartrate of antimony, or, what answers far better, the tartar emetic point made in the manner to be afterwards described, is to be inserted in the puncture, and held there for a few seconds. 4. *The evulsion of the inverted eyelashes is the last step.*—They should be seized lengthways close to their roots, and drawn with a slight jerk. When common dissecting forceps are used, they should be held *below* their shoulder, and close to their points, which are apt to separate a little when the fingers are placed higher up. The best forceps are those made without teeth; the holding part being merely rough polished, so as not to cut hairs. When the eyelashes are exquisitely fine, and slip through even the best made forceps, I have found it an infallible plan to damp their points with a saturated solution of shell-lac in alcohol, and to grasp the hairs for a second or two before pulling them. A momentary, though sharp pain follows the inoculation, and more or less inflammation; but the latter generally subsides in the course of twenty-four hours, and if the operation has been properly done, it recurs in a day or two, in a subacute form, producing a slight pustulation, which, however, is of very limited extent, causing almost no annoyance, but is sufficient to destroy the functions of the bulbs.—*Edin. Monthly Journ. Med. Sci.* 1841.

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43. *Case of temporary Amaurosis of one eye, following the extraction of a tooth.* By James Hunter, M. D.—In July, 1838, a lad, aged 17, applied at the Dispensary on account of a dimness of sight in the left eye, which had come on rather suddenly and under peculiar circumstances. He stated that the sight of both eyes had been very good till four days previously, when, suffering from toothache, he went in the evening to a druggist to have a carious tooth extracted from the left side of the upper jaw. The operation was easily and dexterously performed, and the pain was not particularly excruciating. At the moment the tooth was loosened from the socket, he perceived a brilliant flash of fire before the left eye, which was followed for some minutes by several fainter ones at short intervals. On going to bed an hour or two after, the flashes of fire reappeared, and continued for about an hour, when they gradually ceased. Next

day, he found the sight of the left eye very much impaired, and all objects seen with it appeared enveloped in a thick mist. He also observed a sort of luminous coloured ring, whirling round, as it were, in the interior of the eye. This state of matters continued much the same for the next two days, and, on the fourth day, he thought there was a decided improvement.

"On examining the left eye, its pupil appeared a *very* little more contracted than that of the right eye, but its shape was perfectly regular, and the motions of the iris unimpaired. In every other respect, too, the organ presented a perfectly natural appearance. The general health of the lad, who was of a somewhat sanguineo-nervous temperament, was good. He had no pain in the eye, or in the brow, and no symptoms of cerebral congestion, or of derangement of the digestive organs. When he closed the right eye, the sight of which was sufficiently acute, and looked with the left one at the page of a book, printed in a type which I have since ascertained can be easily read by a good eye at the distance of 48 inches, I found he could not make it out at a greater distance than about 15 inches, and even then with difficulty, and at any nearer distance, though the letters appeared larger, they still seemed to run into each other. When I tried him with type about one-half the size of the first, he was unable to read a single word of it at any distance." "Neither convex nor concave spectacles improved his sight. His perception of colours appeared somewhat impaired, but I had not the means at hand of examining carefully the condition of the eye in this respect. The tooth which had been extracted was the first great molar on the left side of the upper jaw. On making firm pressure with the points of my finger in its socket, there was no unusual tenderness nor any shooting nervous pain produced, and I could not discover any remaining portion of the tooth, nor any splintering of the alveolar process."

Dr. Hunter left the case to nature, and at the end of a fortnight he could distinguish all but very minute objects. He did not return afterwards, so that his recovery was probably complete.—*Ibid.*

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44. *Two new Fasciæ connected with the Muscles of the Human Eye.*—Mr. P. Bennett Lucas has described, in his treatise "*On the cure of Strabismus or squint, by Operation,*" two new fasciæ, to which he gives the name of subconjunctival and submuscular.

These fasciæ he describes as follows:—"Behind the conjunctiva there exists a quantity of loose cellular tissue; upon carefully removing which, a denser layer will be found immediately to cover the orbital aspects of the recti muscles, and to pass along their expanded tendons to the sclerotica, with the anterior surface of which it is in intimate contact, and is traceable along it to the circumference of the cornea, becoming thinner and more identified with the sclerotica as it gains this point.

"This subconjunctival fascia, although exceedingly delicate, is sufficiently strong to offer considerable resistance to even a slightly blunted instrument; and as, in addition to its passing from all the recti muscles to the sclerotica, it also passes from the anterior surface of one muscle to another, it is of importance to be aware of its existence in performing an operation for the section of the tendons of the recti muscles. Unless the subconjunctival fascia be torn through or divided, the passage of an instrument beneath any of the tendons will be attended with difficulty.

"In several eyes, which I have lately examined, this fascia presented different degrees of strength, such as we find to be the case in our examinations of the fascia cooperi; and this anatomical fact most satisfactorily explains the ease with which, in some cases, an instrument can be passed beneath the tendon of the inner rectus muscle preparatory to its section, and the difficulty which accompanies this proceeding in others.

"There exists another fascia in connection with all the muscles of the eyeball, which is deeper seated, of a more uniform density, is much stronger, and of equal importance with that I have just described. It is expanded beneath the muscles and their tendons, passing from one to the other, and covering the